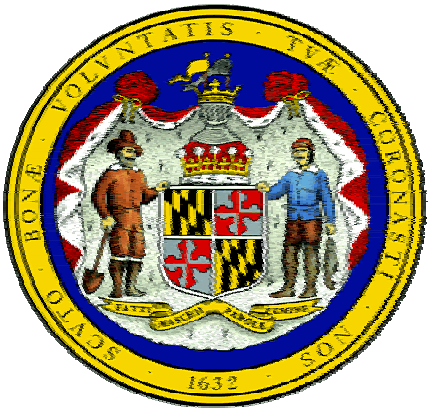
Environmental Assessment:
Nursing Home Industry Issues and Trends



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This report is developed in the context of several changes in the regulatory system in Maryland. It is intended as an educational tool for Commissioners as well as for the general public. In order to understand nursing homes and the nursing home industry, it is necessary to understand the history, current situational issues, and likely future course of the nursing home industry. Although the focus is on Maryland, it is also necessary to understand the federal context, which has an impact on the future of the local industry.

The history of nursing homes in America has been one of constant change. The passage of Medicare and Medicaid in the 1960s, the enactment of prospective payment for hospitals in the 1980s, development of alternatives to nursing homes in the 1980s and 1990s, and the Balanced Budget Act of 1997 and its refinements, have all increased the turmoil for nursing homes as they struggle to redefine their mission.

II. PROFILE OF MARYLAND NURSING HOMES

As of July 2000, there were 272 nursing homes with 30,300 licensed beds. In addition, there were 511 Certificate of Need (CON)-approved beds, 578 waiver beds, and 1,205 temporarily delicensed beds for a total of 32,594 beds. Furthermore, the count of licensed beds is composed of several types of beds including: subacute (603) continuing care retirement community (CCRC) beds (2,350), and freestanding nursing home beds (27,347).

The licensed beds have increased from 1990 to 2000 while CON-approved beds have declined and waiver beds have increased slightly. The ratio of nursing home beds both nationally and in Maryland has declined since 1990. Occupancies have declined statewide from 93.15 percent in 1990 to 88.82 percent in 1997. Most facilities are in the range of 101-150 beds, with a fair number at 51-100 and 151-200. Many of the smaller facilities (0-50 beds) represent either units in CCRCs or subacute units.

Although nursing home serve persons of all ages, about 90 percent of those residing in nursing homes are 65 and older. The development of an older population is due not only to the growing ranks of baby boomers, but also to extended life expectancy. Life expectancy at age 65 increased by only 2.4 years between 1900 and 1960, but has increased by 3.3 years since 1960. The income for the elderly has also improved, with Maryland median income above the national average. Another important future trend includes recent findings indicating that disability levels may actually be declining.

III. REIMBURSEMENT FOR NURSING HOME CARE

Medicaid is the principal payer for nursing home care; in Maryland in 1997, Medicaid paid for 63.7 percent of patient days. The Medicaid reimbursement system used in Maryland is case-mix adjusted based on patient acuity. This provides an incentive for facilities to accept sicker residents. The American Health Care Association reports that residents of Maryland nursing homes had an average of 3.94 activities of daily living (ADL) dependencies as compared to 3.67 for the U.S. Although aggregate spending on nursing homes by Medicaid has increased from 1990 to 1999, such spending as a percentage of total Medicaid spending has stayed fairly constant over time.

Although a small proportion of care is reimbursed by Medicare, it is a major payer for short term and subacute care. Nationally Medicare spending in skilled nursing facilities grew from $578 million in 1986 to $13.6 billion in 1998. In order to balance the federal budget and reduce Medicare spending, Congress passed the Balanced Budget Act (BBA) of 1997. Under the BBA, instead of a cost-based system based on reasonable costs, skilled nursing facilities (SNFs) received a set payment, case-mix-adjusted, for each day of care provided to a Medicare beneficiary based on average daily rates for SNF services provided in 1995. Although refinements were made in the Balanced Budget Refinement Act of 1999, the basic concepts of prospective payment remain and require a major shift in the mindset of nursing home providers.

Because of the major changes in reimbursement, eight nursing home chains have declared bankruptcy since last year. According to the American Health Care Association, this represents about 10 percent of beds nationally. These companies tended to blame the changes in Medicare reimbursement for their financial woes; there were in fact many factors involved. Delmarva Foundation is currently under contract with the Health Care Financing Administration (HCFA) to study the impact of prospective payment in Maryland.

In Maryland, there are several companies that operate multiple facilities. In fact, seven multi-facility operators operate more than one-third of the licensed beds in Maryland. There has been increasing merger activity in Maryland from 1997 through 2000. Increasingly, this has been due to corporate restructuring.

IV. QUALITY OF CARE

Nursing homes have suffered in the past few years from the simultaneous cuts in reimbursement coinciding with increased scrutiny in areas of quality of care. Many federal quality of care initiatives have been launched since 1986. A March 1999 General Accounting Office report severely criticized Maryland's regulatory oversight of the nursing home industry. This led to the creation of a Maryland Nursing Home Task Force which met from July to December of 1999. The recommendations of this Task Force formed the basis of a legislative package of bills that was introduced during the 2000 session of the Maryland General Assembly. Six quality of care bills passed and are currently being implemented.

V. ALTERNATIVES TO INSTITUTIONALIZATION

Besides facing financial pressures and quality concerns, nursing homes are also facing a public relations challenge. In public opinion polls, many are stating that they will go anywhere but a nursing home. Many nursing homes are working on developing a more positive image. Currently, many alternatives to nursing home care exist.

The Medicare home health program was started in 1965 as a humane concept of providing care for persons in their home and aiding recovery in a familiar environment. Due to both the popularity of the concept and the availability of Medicare funding, home health has grown tremendously. Home health reimbursements have grown by 300 percent nationally in the past six years alone. The home health industry now finds itself in similar straits to the nursing home industry –with dual pressures of cuts from the Balanced Budget Act and increased scrutiny on quality of care.

Due to consumer preferences for less institutional placement, assisted living has become a growth industry. The Assisted Living Federation of America estimates that there were 362,014 assisted living beds in 1991 compared to 777,801 in 1999. In Maryland, it is estimated that there are currently 13,000 to 15,000 persons in 2,500 assisted living facilities. The popularity of assisted living has shifted many of the lighter care residents away from nursing homes.

Another popular model of care is continuing care retirement communities (CCRCs). There are 30 CCRCs in Maryland with 2,350 nursing home beds. Since persons need to enroll and pay both entrance fees and monthly fees, CCRCs are in competition with nursing homes, especially for those residents with the financial resources to pay for care. Recent legislation modified both the calculation of CON-exempt beds and the conditions under which limited direct admission may occur. This could potentially cause greater competition between community nursing homes and CCRCs. Still another variation on this model is continuing care at home. This is a new model for which regulations became effective May 15, 2000.

Two other models of care delivery are the Program for All-Inclusive Care for the Elderly (PACE) and Social Health Maintenance Organizations (S/HMOs). PACE is a capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity that features a comprehensive model and social delivery system using a multidisciplinary team approach in a adult day health center, supplemented by in-home and referral services in accordance with the participants' needs. The BBA of 1997 established PACE as a permanent entity within the Medicare program and enabled states to provide PACE services to Medicaid beneficiaries as state option. In January 1996 Johns Hopkins initialed a pre-PACE site; in January 1999 HCFA approved a waiver for full capitation. A S/HMO is an organization that provides the full range of Medicare benefits offered by standard HMOs plus additional services including: care coordination, prescription drug benefits, chronic care benefits covering short term nursing care, a

full range of home and community based services. In March 1998, HCFA approved Maryland's proposal for a planning grant to build on a Medicare HMO, develop a second generation S/HMO for both Medicare only and dual eligible older adults, and add long term care and other services. HCFA approved a no-cost extension of the planning project through June 2000. These models probably cannot be expanded on a broad scale; however, they offer insights on how to provide long term care services in ways that may be more effective than traditional models of delivering care.

VI. LOOKING FORWARD

One impact being felt throughout society in general, and the health care system in particular, is the impact of consumer choice. As baby boomers age, they are demanding more options, more personal input, more choices. This generation is better educated; with increases in education come increasing income and better chances of good health. Some feel that there are two inescapable facts guiding predictions of the future: one is that Americans are getting older. The other is that they are getting smarter—or at least better educated. Consumers have become more informed, and the nursing home industry must be able to compete in this realm to survive. Successful nursing homes will be those who create the right mix of services, giving the public what it wants while retaining the revenues they need to survive.

I. INTRODUCTION

A. Purpose

This paper is designed to analyze, from a policy perspective, a range of environmental factors impacting on the current and future operation of Maryland nursing homes. The *Environmental Assessment: Nursing Home Industry Issues and Trends* has been developed in the context of several changes in the regulatory system in Maryland. First, it is presented to a new Commission, the Maryland Health Care Commission, which just became effective October 1, 1999. This document is intended as an educational tool for the Commission. As a policy and regulatory body, the Commission has an interest in anticipating changes in the health care system, so as to be able to formulate proactive policies. In order to understand nursing homes and the nursing home industry, it is necessary to understand the history, current situational issues, and likely future course of the nursing home industry. Although the focus of this paper is on nursing homes in Maryland, it is also necessary to understand the federal context, which has an impact on the future of the local industry. Secondly, this paper represents an initial step in the process of updating the State Health Plan chapter on long term care services. Finally, this Environmental Assessment is a prelude to a study of the entire Certificate of Need (CON) program that will be undertaken by the Commission later this year. Areas to be included in the CON study this year include nursing home, home health, and hospice services. The outcome of this study will also help determine how the Commission plans for and regulates long term care services in Maryland.

B. History

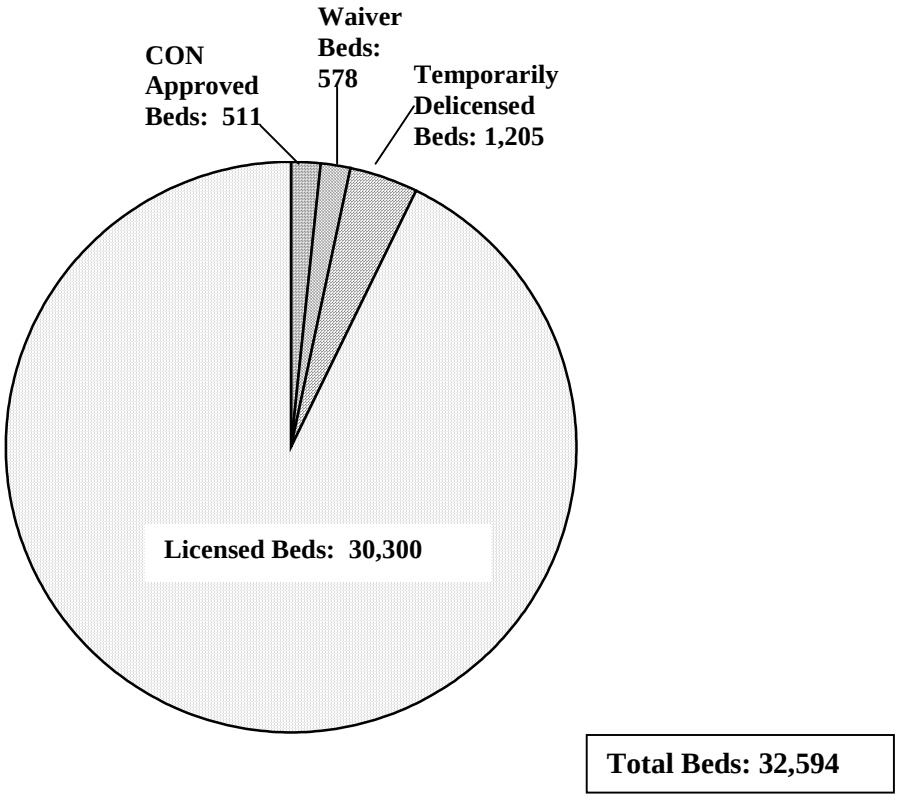
The history of nursing homes in the United States has been one of constant change. Starting in the 1960s with the passage of Medicare and Medicaid as a source of reimbursement, nursing homes evolved from old age "rest homes" to major providers who offered an increasingly medical model of care. With the enactment of prospective payment for hospitals in the 1980s, nursing homes found themselves taking care of increasingly more medically complex patients as hospitals discharged patients "sicker and quicker". The development of alternatives to nursing homes in the 1980s and 1990s and the Balanced Budget Act of 1997 further increased the turmoil for nursing homes as they struggled to redefine their mission. For more details on the evolution of the long term care system in Maryland, see **Appendix A.**

II. PROFILE OF MARYLAND NURSING HOMES

A. Maryland Nursing Homes by Operating Status and Type

As of July 2000, there were **272** nursing home facilities with **30,300** licensed and operating beds. In addition, there were: **511** certificate of need-approved beds (having an approved certificate of need, but not yet licensed and operational), **578** waiver beds (having a waiver from certificate of need, but not yet licensed), and **1,205** temporarily delicensed beds (having permission to hold certain beds off-line). There were a combined total of **32,594** beds in Maryland nursing homes as of July 2000. These terms and categories are defined in more detail below. The distribution of the total beds is shown in Figure 1.

Figure 1:
Distribution of Total Nursing Home Beds by Operating Status: Maryland, July 2000



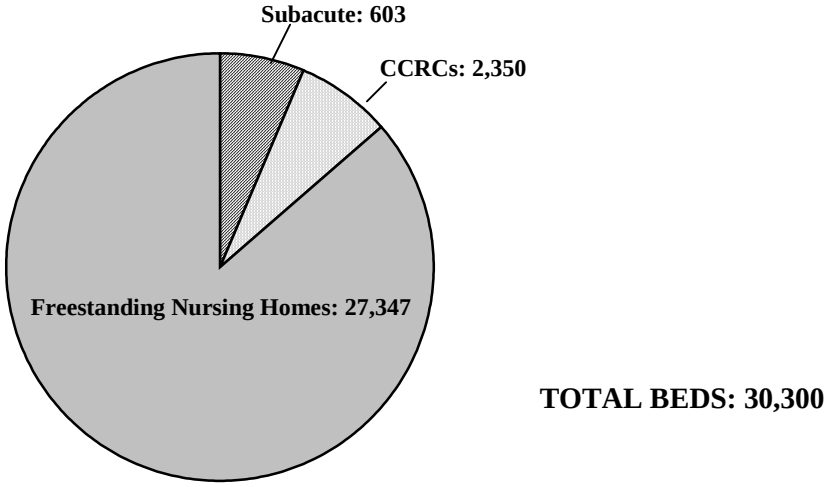
Source: Maryland Health Care Commission , Inventory of Comprehensive Care Beds, July 2000 (unpublished)

Licensed nursing home beds have received a comprehensive care (nursing home) license from the Office of Health Care Quality under COMAR 10.07.02. Such facilities have either received a certificate of need, or been grandfathered into the program. The licensed beds are also operating beds**. CON-approved** beds have received a certificate of need from the Maryland

Health Care Commission (or its predecessor agency the Maryland Health Resources Planning Commission) by meeting all of the appropriate standards under COMAR 10.24.01 (certificate of need regulations) as well as COMAR 10.24.08 (the State Health Plan chapter that addresses long term care services). **Waiver** beds are those approved under COMAR 10.24.01.02(A)(2)a; these generally involve a change in capacity of 10 beds, 10 percent, or less. **Temporarily delicensed** beds are those beds at facilities granted permission by the Commission to temporarily take beds "off line" (out of service) usually for a period of one year pending plans to delicense or otherwise use the beds. These beds are removed from the license for that facility, but have been kept in the inventory maintained by the Commission. These practices may change pending the outcome of regulations regarding off-line capacity scheduled for initial proposal at the July 21, 2000 Commission meeting.

Furthermore, the count of licensed beds is composed of several types of beds. These beds that are licensed as comprehensive care (nursing home) beds actually include other categories as shown in Figure 2 and defined below.

Figure 2
Distribution of Licensed Nursing Home Beds by Type: Maryland, 2000



Source: Maryland Health Care Commission, Inventory of Comprehensive Care Beds, July 2000 (unpublished).

Subacute is not a licensure category; such care can be provided in hospitals or nursing homes. Subacute refers to care defined under COMAR 10.24.05 as follows:

> Subacute care means comprehensive inpatient care that is designed for someone who has had an acute illness, injury, or exacerbation of a disease process whose treatment does not require to any significant degree high technology monitoring or complex diagnostic procedures, and which has the following characteristics:
>
> - It is goal-oriented treatment rendered immediately after, or instead of, acute hospitalization to treat one or more specific active complex medical conditions or to administer one or more

technically-complex treatments in the context of a person's underlying long-term conditions and overall situation;

- It requires the coordinated services of an interdisciplinary team including physicians, nurses, and other relevant professional disciplines, who are trained and knowledgeable to assess and manage these specific conditions and perform the necessary procedures.
- It is given as part of a specifically-defined program within a dedicated unit, regardless of site;
- It is generally more intensive than traditional comprehensive care facility care an less intensive than acute care; and
- It requires daily to weekly recurrent patient assessment and review of the clinical course and treatment plan for a limited period of several days to several months, until the patient's condition is stabilized or a predetermined treatment course is completed.[1]

Continuing care retirement communities (CCRCs) refers to communities, usually including independent living units, assisted living units, and nursing homes, regulated by the Maryland Department of Aging under Article 70B and COMAR 14.11.02. To distinguish such communities from senior housing complexes and other types of living arrangements for seniors, a community must meet the following criteria for certification as CCRC:

- Its subscribers pay an entrance fee that is, at a minimum, three times the weighted average of the monthly service fees;
- Subscribers sign a contact for a period of more than one year, usually for life, that requires either a transfer of assets or payment of an entrance fee and monthly fees to live in a secure and protected environment; and
- The community provides, at a minimum, access to medical and nursing services or other health-related benefits.

The nursing home beds in CCRCs are also regulated under the Commission's Certificate of Need (CON) program (COMAR 10.24.01) and under planning regulations (COMAR 10.24.08). If a CCRC applies for, and successfully obtains a CON for nursing home beds, it can serve both its own enrolled residents as well as the general public. However, CCRCs can also obtain nursing home beds though a CON exemption under COMAR 10.24.01 B(11)(b)(ii). To qualify for this exemption, a CCRC must satisfy three criteria:

- Beds obtained through the waiver must not exceed the ratio of one bed for every five independent living units (or 20 percent). This has recently been changed to 24 percent for those communities with fewer than 300 independent living units.
- The CCRC must serve exclusively its own residents in the nursing home beds; it cannot market directly to the general public. This has also been recently modified for admission of two spouses (or two persons having a long-term significant relationship) where one is admitted to an independent or assisted living unit and one is admitted directly into a nursing home bed. Other exceptions involve admission of persons directly into a nursing home bed who have a reasonable likelihood of eventual transfer to an independent or assisted living unit. These admissions cannot exceed 20 percent of the nursing home beds and cannot cause occupancy to exceed 95percent.*
- It must provide nursing home care on the same campus as the housing units.[2]

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[1] Weiss, Cathy and Rebecca Rosenstein, Ph.D., Subacute Care Project: Preliminary Report. December, 1995.

*These changes made in legislation passed during the 2000 legislative session with regulations to be proposed at the July 21, 2000 Commission meeting.

[2] Continuing Care Retirement Communities: An Examination of Policies Governing the Exemption of Nursing Home Beds from Certificate of Need Review. Final Report. February, 1999.

More discussion on CCRCs and their impact on nursing home beds is found in section V of this report.

In order to have some perspective on these numbers, it is useful to look at the changes from 1990 to 2000:

Table 1
Changes in Nursing Home Bed Capacity: Maryland, 1990-2000

Year	Licensed Beds	CON-Approved Beds	Waiver Beds	Total Beds
1990	26,894	2,626	504	30,024
2000	31,505*	511	578	32,594
CHANGE '90-'00	+4,611	-2,115	+74	+2,570

Source: Maryland Health Care Commission, Inventory of Comprehensive Care Beds, July 2000 (unpublished) and Commission inventories 1990.

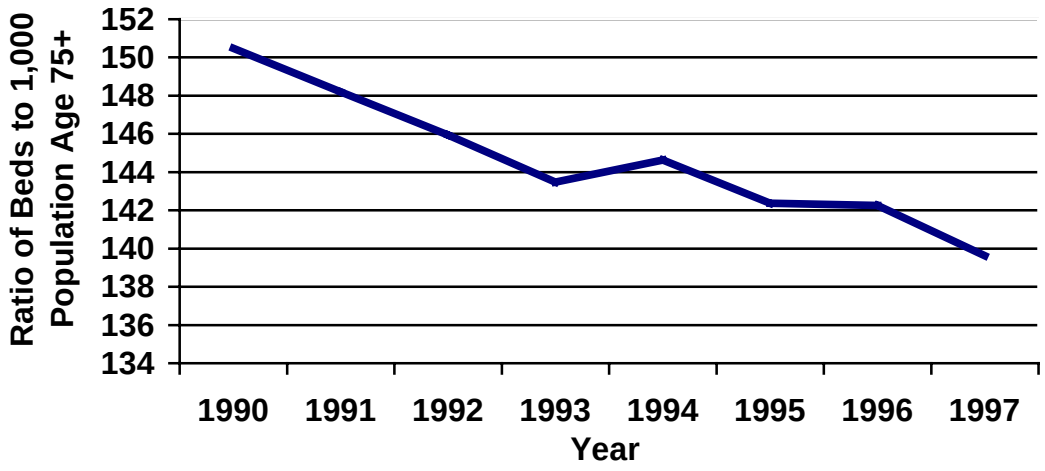
* Note: the bed count for 2000 includes both licensed as well as temporarily delicensed beds.

The licensed beds have increased, but, as will be discussed below, this has been at a fairly slow rate. Also, it should be noted that the count of 31,505 beds includes 1,205 temporarily delicensed beds, which in the near future will need to either be brought on line or removed from the inventory. The certified beds have decreased because the Commission has made an effort to decertify those beds that have not come on line in a timely manner. Waiver beds have increased slightly, but these are beds that fall into the category of 10 beds or 10 percent (whichever is lower) that facilities can request without undergoing a full CON review. These waiver beds cannot be banked, and more beds cannot be obtained until these beds become licensed and operational.

In addition, there have been changes in the nursing home bed-to-population ratio. SMG, Marketing Group, Inc. reported that the rational ratio of nursing home beds per 1,000 population aged 65 and over fell from 51.9 in 1998 to 49.7 in 1999—a decline of 4.2 percent. Maryland, according to this national survey, is at the U.S. average with a bed-to-population ratio of 49.7 in 1999.[3] The ratio of nursing home beds to population aged 65 and over in Maryland has remained fairly steady at 50 beds per 1,000. The ratio of beds to the population aged 75 and older, a growing group, shows more decline over time as illustrated in Figure 3.

[3] Aventis, Managed Care Digest Series 2000, p. 16. Data derived from SMG Marketing Group, Inc.

Figure 3
Nursing Home Beds Per 1,000 Population
75 Years and Older: Maryland, 1990-1997



Source: Maryland Health Care Commission files and; population projections from Maryland Office of Planning, updated February 2000.

It is also interesting to observe the changes in nursing home capacity and utilization over time.

Table 2
Nursing Homes, Beds, and Percent Occupancy:
Maryland, Fiscal Years 1990-1997

Year	Nursing Homes	Licensed Beds	Percent Occupancy
1990	226	26,894	93.15%
1991	225	27,255	93.75%
1992	227	27,594	94.10%
1993	227	27,871	93.37%
1994	231	28,844	92.38%
1995	244	29,128	92.15%
1996	251	29,990	91.59%
1997	262	30,307	88.82%

Source: Maryland Health Care Commission (Data for 1990-1994 is from the Maryland Health Resources Planning Commission's Maryland Nursing Home Occupancy reports; data for 1995-1997 is unpublished data from the Maryland Long Term Care Survey.)

As can be seen in Table 2, although the number of nursing homes and beds has risen slightly, the occupancies have dropped steadily since 1992. In the past, nursing home occupancies were generally about 95 percent. This has dropped both in Maryland and

nationwide as nursing homes have faced stiff competition from other types of providers. This will be discussed in more detail below.

Another factor to consider is how many beds each nursing home facility has, or how beds are distributed across the state by facility. This information is shown in Table 3. It should be noted that this inventory includes both subacute units and nursing homes units in continuing care retirement communities; both of these types of units tend to be smaller and account for the fairly large number of beds in the 0-50 bed category.

Table 3
Distribution of Nursing Homes by Bed Size Category and Region: Maryland, 2000

Region	0-50 Beds	51-100 Beds	101-150 Beds	151-200 Beds	201-250 Beds	251-300 Beds	300+ Beds
Western Maryland	5	14	15	6	2	0	0
Montgomery County	8	10	12	6	0	1	2
Southern Maryland	6	4	11	6	3	1	0
Central Maryland	35	20	34	29	7	1	4
Eastern Shore	5	6	9	3	2	0	1
TOTAL	59	54	81	50	14	3	7

Source: Maryland Health Care Commission, Inventory of Comprehensive Care Beds, July 2000 (unpublished).
Note: This is based on licensed beds, including subacute units and CCRCs.

B. Elderly Population in Maryland

In order to place the nursing home industry in context, it is necessary to examine the target population of nursing homes. Although nursing homes serve persons of all ages, about 90 percent of those residing in nursing homes are 65 and over. Therefore, the focus of this section will be the 65 and older Maryland population.

Nationally, it is well documented that the population is aging, due in large part to the aging of the large baby boom generation, i.e. those born between 1946 and 1964. For example, in 1900, the 65 and older population nationally represented 4.1 percent of the total population. By 2040, the 65 and over age group in the U.S. will be 20.3 percent of the total population. Similarly in Maryland, the 65 and older population represent 11 percent of the total population in 2000. This is expected to rise to 16 percent in 2020.[4]

[4] Maryland Office of Planning, Population Projections, June 1999 revisions.

The development of an older population is due not only to the growing ranks of baby boomers, but also to extended life expectancy. A child born in 1997 could expect to live to 76.5 years, about 29 years longer than a child born in 1900. This is due primarily to reduced death rates for children and young adults. Life expectancy at age 65 increased by only 2.4 years between 1900 and 1960, but has increased by 3.3 years since 1960.[5]

The income for the elderly has also improved. Income for households headed by persons 65+ was reported at a median income nationally of $31,568 in 1998. For Maryland, persons fare better than the national average. For all ages, the median income per household in Maryland in 1998 was $50,016 compared to $38,885 nationally. In terms of the 65+ population, 8.9 percent were below the federal poverty limit in Maryland as compared to 10.6 percent for the U.S.[6]

With increasing age comes increasing levels of disability. In 1990-1991, 9 percent of persons aged 65-69 needed assistance with everyday activities as compared to 50 percent of those 85 years and over.[7] However, recent research findings indicate that previous levels of disability may actually be declining. According to analyses from the National Long-Term Care Surveys, the percentage of both institutional and community-based persons aged 65+ who were disabled declined between 1982 and 1984. For those in the community, the percentage disabled dropped from 18.0 percent in 1982 to 16.0 percent in 1994. For those in institutions, the proportion declined from 5.7 percent to 5.1 percent for the same time period. From 1982 to 1994, the proportion of the population 65+ who were nondisabled rose from 76.3 percent to 78.9 percent. "Although this is a striking finding, the disability decline in the older population (estimated from the 1982 to 1994 NLTCS) is consistent with findings from other surveys of recent disability trends in the U.S. (Waidmann and Manton, 1998).[8]

[5] Administration on Aging, Profile of Older Americans: 1999. Website:http://www.aoa.dhhs.gov/aoa
[6] Ibid. and U.S. Bureau of the Census. Current Population Reports, p. 60-206. Money Income in the U.S. 1998
[7] U.S. Census Bureau. Sixty-Five Plus in the United States, May 1, 1995.
[8] Liu, Korbin, Kenneth G. Manton, Cynthia Aragon. Changes in Home Care Use by Older People with Disabilities: 1982-1994. AARP Public Policy Institute, January , 2000.

III. REIMBURSEMENT FOR NURSING HOME CARE

A. Maryland Medical Assistance Program (Medicaid)

Although national attention often focuses on Medicare, the principal payer for nursing homes, both nationally and in Maryland, is Medicaid. In fiscal year 1997, Medicaid paid for 63.7 percent of total patient days in Maryland nursing homes. Although Medicaid is the principal payer for nursing home care, it should be noted that Medicaid is the payer of last resort and pays only when the resident cannot pay. Also, residents must spend down and contribute nearly all pensions and other ongoing income to the cost of their care; they can keep $40 per month as a personal needs allowance.

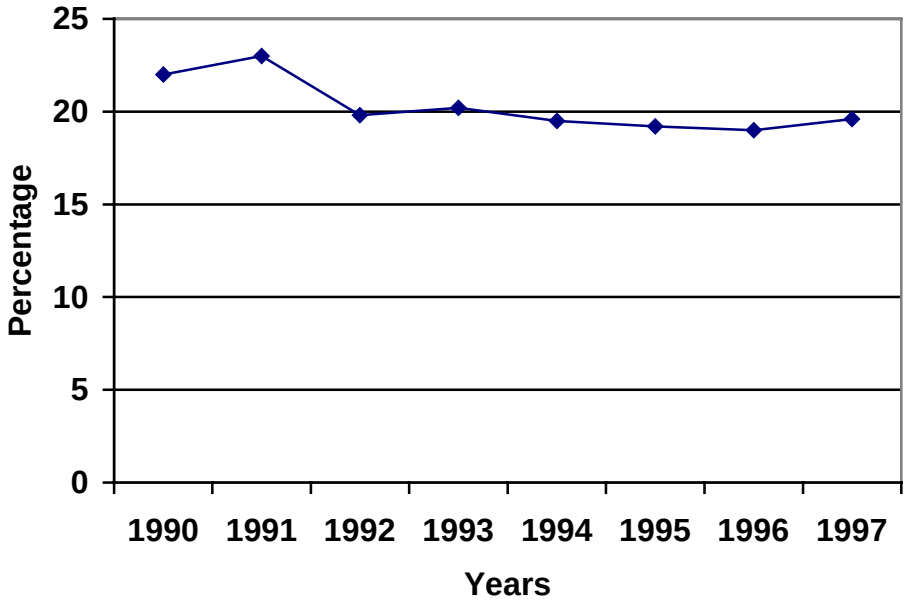
Since Medicaid is a joint federal-state program, the method of reimbursement varies from state to state. In Maryland, payment for nursing services is based on the level of care required by each resident. It is thus a case-mix adjusted form of reimbursement. Such a methodology is designed to provide a greater incentive for nursing homes in Maryland to serve sicker residents and, on average, Maryland nursing home residents are more dependent in their activities of daily living (ADLs) than the national average. The American Health Care Association reports that residents of Maryland nursing homes had an average of 3.94 ADL dependencies as compared to 3.67 for the U.S.[9]

The current Medicaid reimbursement system for nursing homes in Maryland has been in effect since 1983. At that time, the objectives were to develop a system that was cost-related and administratively efficient, provided increased access for Medicaid residents, and encouraged quality care. Additional goals were to recognize fair market value of assets used, to recognize factors causing cost differences, and to include incentives for cost containment. There have been adjustments to the system since it was designed in 1983, but the basic structure remains unchanged.

The overall system design consists of four cost centers: administrative and routine, nursing service, other patient care, and capital. There are cost ceilings, with reimbursement of costs up to the ceilings and efficiency payments to facilities with costs below the ceilings. The ceiling and efficiency payments are adjusted as needed over time. Reimbursement is based on geographic regions and includes a small facility class for administrative and routine costs. As Figure 4 indicates, this method of reimbursement has allowed the State to keep the percentage spent by Medicaid on nursing home care at a fairly stable level, even as the population has aged. Although aggregate spending on nursing homes by Medicaid has increased from $272,790,198 in FY 1990 to $559,140,121 in FY 1999, such spending as a percentage of total Medicaid spending has stayed fairly constant over time and actually decreased slightly.

[9] American Health Care Association Nursing Facility Sourcebook, 1998

Figure 4: Spending on Nursing Homes as a Percentage of Total Medicaid Spending: 1990-1997



Source: Medicaid Year in Review, 1990-1997; Medicaid files for 1998, 1999.

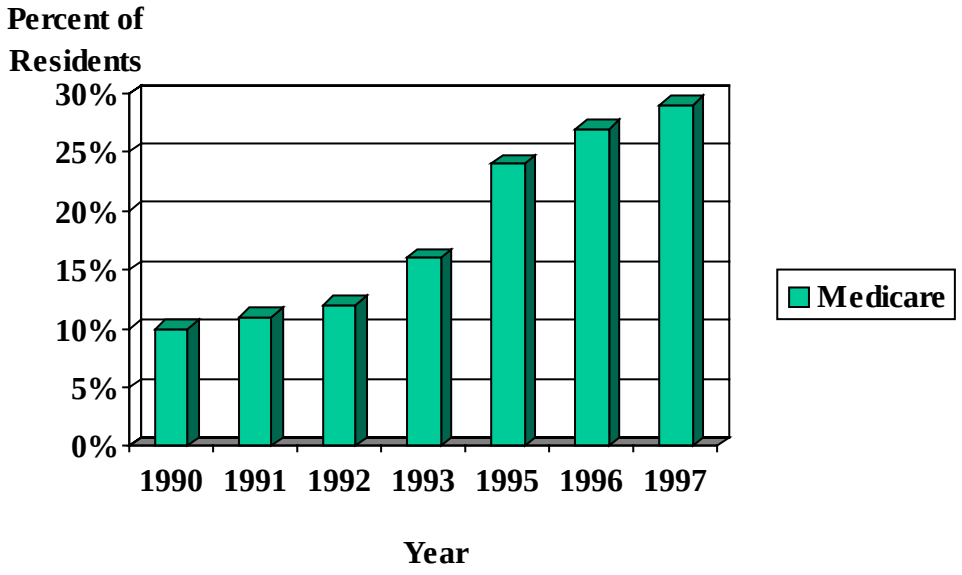
B. Medicare Program

Although a small proportion of care is reimbursed by Medicare, it is a major payer for short term and subacute care. Until the passage of the Balanced Budget Act (see next section), nursing homes enjoyed a system of reimbursement from Medicare which essentially reimbursed whatever they billed, usually a fee based on their costs of care ("reasonable costs"), subject to ceilings adjusted for urban or rural locations. Nursing homes were paid an interim rate, subject to final cost settlement. Although Medicare represents a fairly small proportion of care provided overall in nursing homes (9.3 percent nationally in 1998, as reported by the American Health Care Association), with an increasingly sick patient population, more facilities started to offer skilled nursing care. According to the Health Care Financing Administration (HCFA) the percentage of total nursing facility expenditure attributable to Medicare more than tripled from $2.8 billion in 1992 to $10.2 billion in 1997.[10] Since Medicare focuses on paying for post acute (following a hospitalization) care with a limit of up to 100 days, facilities have tried to maximize their Medicare reimbursement by focusing on the provision of skilled care and by developing Medicare distinct part units. Several hospitals and nursing homes also started providing subacute (short-term, post-acute) care as a way of maximizing reimbursements from Medicare. As will be discussed in the next section, this became a major problem when Medicare changed its reimbursement methodology with the enactment of the Balanced Budget Act. In Maryland, as

[10] Childs, Nathan "How Will Long Term Care Remember the Clinton Years?" Provider, November, 1999.

shown in Figure 5, payer source on admission attributable to Medicare grew from 10 percent of residents in 1990 to 29 percent in 1997.

Figure 5
Trends in Payer Source on Admission
to Maryland Nursing Homes: 1990-1997



Source: Maryland Long Term Care Surveys, 1990-1997

Nationally, Medicare spending in skilled nursing facilities (SNFs) grew from $578 million in 1986 to $13.6 billion in 1998.[11] At the same time, Medicare costs for home health were increasing at an even faster rate. From 1987 to 1994, combined Medicare and Medicaid outlays for long-term care rose by 153 percent for nursing homes and 543 percent for home health care.[12] As a result, the federal government felt that it needed to take drastic action to stop this spiral of increasing costs.

C. Balanced Budget Act of 1997

A significant change to the operation of nursing homes was the enactment of the Balanced Budget Act (BBA) of 1997. As part of the overall effort to balance the federal budget, Congress and the President passed the BBA, which was intended to reduce Medicare payments in 1999 from $248 billion to $232 billion. However, the Congressional Budget Office estimated that actual payments for 1999 were only at $210 billion.[13] The Health Care Financing Administration (HCFA) began phasing in Medicare prospective payment for skilled nursing

[11] Salganik, M. William. "Golden Years Fade for Nursing Home Chains" The Baltimore Sun, 03/05/00.
[12] Bodenheimer, Thomas, M.D. "Long-Term Care for Frail Elderly People—the On Lok Model." The New England Journal of Medicine, Vol. 341, No. 17, pp. 1324-1327.
[13] Childs, Nathan, op.cit., November, 1999.

facilities over four years starting July 1, 1998; final rules, however, were not available until July 30, 1999. During the first year, 75 percent of a facility's Medicare payment would be based on its maximum allowable 1995 costs adjusted for inflation and 25 percent would be based on the national PPS rate. This ratio changes to 50:50 during the second year, 25:75 in the third year, and 100 percent federal by the fourth year.[14]

Under the BBA, instead of a cost-based system based on "reasonable" costs, SNFs received a set payment for each day of care provided to a Medicare beneficiary. The per diem rate was based on the average daily rate of providing all Medicare-covered SNF services in 1995. Since not all patients require the same amount of care, a case mix adjustment factor was incorporated, permitting some flexibility in the payment method. The prospective payment system (PPS) is based on a case mix system of Resource Utilization Groups (RUGs), which combines routine, ancillary, and capital costs into an all-inclusive case mix-adjusted rate. The RUGs are based on data from the resident assessment instrument called the Minimum Data Set (MDS) 2.0. The rate also includes wage adjustments based on geographic variations using the hospital wage index. Hospital swing beds and low volume SNFs (fewer than 1,500 days per year) are not subject to the PPS rates until 2000.[15]

[14] HCIA Inc. and Arthur Andersen LLP. The Guide to the Nursing Home Industry, 2000, p.viii.
[15] Health Financial Management Association, "HFMA Knowledge Network Highlights: Skilled Nursing Facilities Prospective Payment System and Consolidated Billing".
* This item was modified under BBA refinement, see next page.

Highlights of the Balanced Budget Act of 1997 relating to Skilled Nursing Facilities:

- **Introduction of a prospective payment system (PPS)**: This payment system, phased in over four years beginning July 1, 1998, gave providers a fixed payment per day to cover all care provided to a resident, as opposed to the former cost-based system. There was an equalization of rates between freestanding and hospital-based SNFs with rates all inclusive of routine, capital, and ancillary costs.

- **Payment based on resource utilization groups (RUGs)**: RUGs have been tested and developed in several phases. These are called RUGs III, representing the third iteration of RUGs. The PPS system is based on 44 RUGs groupings.

- **Therapy Services Caps**: Beginning in 1999, the BBA caps Part B rehabilitation services. There is a cap of $1,500 per year on occupational therapy and a combined cap of $1,500 per year on speech therapy and physical therapy. *

- **Transfer and discharge**: By treating the movement of a patient from a PPS hospital to a SNF or home health agency as a transfer rather than a discharge, the BBA intended to save an estimated $1.3 billion. This reduces the DRG by paying a blended DRG/per diem rate if the patient is moved early from a group of the 10 most frequently used DRGs.

- **Consolidated billing**: SNFs will bill for all covered services provided to residents under Part B with payment being made to the SNF (except physician and physician-related services). *

- **Repeal of the Boren Amendment**: This amendment, enacted in 1980, required that states set Medicaid rates for nursing facilities that are reasonable and adequate to meet mandated federal standards for quality care. This provision of the BBA repealing the Boren Amendment was effective October 1, 1997

- **No Block Grants**: All Medicaid services, including nursing facility services, remain as an entitlement for the poor and disabled. There are no block grants or per capita grants.

- **Asset transfers**: Those who provide legal counsel or assistance in helping a person to knowingly dispose of assets to become eligible for Medicaid can be prosecuted.[16]

After the enactment of the BBA, many nursing homes, subacute care providers, and others complained to HCFA that the cuts were too drastic. Several long term care companies declared bankruptcy. The American Health Care Association, the American Association of Homes and Services to the Aging, and others lobbied against provisions of the BBA. They even launched a major advertising and letter writing campaign. The final result was an adjustment to the BBA called the Medicare, Medicaid and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999. This is often referred to as the "BBA Refinement Act".

[16] American Health Care Association (AHCA) Briefing Room, "1997 Federal Budget Act Will Change LTC", August 27, 1997. WEBSITE: http://www.ahca.org/

* This item was modified under The Balanced Budget Refinement Act of 1999.

The Medicare, Medicaid and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 Highlights Relating to SNFs:

- A 6 month add-on to the RUGs III categories: There would be a 20% add-on for six months (beginning April 12, 2000) to more accurately account for non-therapy ancillary costs for 12 RUGs categories.
- An increase in the federal rate for all categories of patients by 4% in FY 2001 and FY 2002.
- The option for facilities to go directly to the full federal reimbursement rate, effective with a cost reporting period on or after January 1, 2000.
- Exclusions from the prospective payment system for certain prosthetics, certain chemotherapy, and for ambulance services for dialysis patients, starting April 1, 2000.
- Provisions for Part B add-ons for facilities participating in certain demonstration projects and for those who serve a high proportion of AIDS patients in 2000-2001.
- A 2-year moratorium on implementing the Part B therapy caps and revises the BBA mandated study to develop an alternative system for therapy services payments.[17]

Although these refinements avert the severity of the initial BBA, the concept of prospective payment and reduction in Medicare payments is still in place. The notion of retrospective payment to cover all or most expenses has vanished. This has resulted in, and will continue to require, a major shift in the mindset of long-term care providers.

D. Bankruptcy Among Nursing Home Chains

Because of the major changes in reimbursement described earlier, many long-term care companies have merged or even declared bankruptcy. These companies have filed under Chapter 11 bankruptcy protection. It should be clarified that Chapter 7 results in an organization's dissolution, while Chapter 11 gives a company the opportunity to negotiate better interest rates on its debt and streamline its operations by shedding unprofitable businesses, among other things. Filing for bankruptcy protection provides a company with an automatic stay, preventing the company's creditors from taking any action to collect debt or foreclose on collateral.[18] According to the American Health Care Association, (AHCA), 1,675 skilled nursing facilities out of 17,000 (or about 10 percent) nationally have declared bankruptcy. During the past six months, there were perhaps more bankruptcies among major long-term care providers than at any other time. The most notable of these are listed in Table 4.

[17] Mid-Atlantic Nonprofit Health and Housing Association (MANPHA) Newsletter, December, 1999, p. 2.
[18] Vickery, Kathleen. "Rebuilding through Bankruptcy". Provider, June, 2000.

Table 4
Bankruptcies Among Nursing Home Chains: 1999-2000

Nursing Home Company	Year of Bankruptcy
Vencor, Inc.	1999
Sun Healthcare Group, Inc.	1999
Mariner Post Acute Network, Inc.	1999
Lenox Health Care, Inc.	1999
Frontier Group, Inc.	1999
Newcare Health	2000
Integrated Health Services	2000
HMU	2000

Source: Somerville, Sean and Kristine Henry. "Health Care Companies say Federal Cuts Hurt Industry". The Baltimore Sun, February 3, 2000, p. D-1 and Provider, June, 2000.

In addition to those companies listed in Table 4, the 327 facilities owned by Genesis Health Ventures are currently undergoing debt restructuring.[19] Of those listed in Table 4, Vencor, Sun, and Mariner are large national chains. Lenox, Frontier, Newcare, and HMU are smaller, more localized firms. It should be noted that although Integrated Health Care had its headquarters in Maryland, it has no Maryland facilities. Integrated Health Services, which made several acquisitions in anticipation of less severe cuts, swelled to 84,000 employees with $3.0 billion in annual revenue. The company just built a new headquarters in Maryland's Hunt Valley area of Baltimore County, financed by the State ($2.5 million) and Baltimore County ($800,000). They had $1.0 billion in equity and $3.0 billion in debt.

Companies that have merged or declared bankruptcy have cited the changes in Medicare reimbursement for their financial woes. Although it is true that the drastic changes in the form of a prospective payment system did cause serious downturns with these markets, this was an announced, anticipated change, which many other companies managed to weather. The ones that were the most severely impacted were heavily invested in Medicare post-acute products, and were also heavily in debt. Most of the losses were due to "one-time transactions, including cost restructuring and the writing down of assets."[20]

The bankruptcy woes seemed to hit the larger chains harder than some of the smaller nursing homes providing more "traditional" types of nursing care. "Some nursing homes, particularly those that belong to large chains, had increased their profitability by expanding into ancillary services, thus increasing their volume of Medicare subacute patients. Adding these services often required borrowing capital, placing the homes in a debt situation that is hard to reverse when revenues decline. Also, the PPS system limits reimbursement for ancillary services, so these homes are now being hit even harder than most. Indeed, the stock prices of some of the large chains demonstrate their strain—in 1998, the stock prices of the eight largest publicly traded subacute and long-term care companies fell by an average of 56.7 percent. The second worst year, historically was 1988, and then the drop was only 10 to 15 percent."[21] So, it

[19] "Minnesota Nursing Facility Company Files for Bankruptcy". Provider, June, 2000.
[20] Adams, "Medicare: New Rules Make Nursing Home Admission Harder". Wall Street Journal, December 23, 1999.
[21] HCIA Guide, 1999.

appears reasonable to assume that a combination of factors and actions caused the financial situation for these companies.

Regardless of the root cause, the bankruptcy of nursing home chains has an impact not only on the nursing home system, but also on the broader health care system. If nursing homes, due to fears of BBA impact, refuse to take complex medical and rehabilitation patients, such patients will be backed up in hospitals. If home health agencies are undergoing a budget crisis at the same time, this will also put pressure on hospitals. Hospitals are also trying to discharge patients; this is putting pressure on the entire health care system, and especially on the patients whom no one wants to serve.

Although much has been written about the draconian effects of the BBA, Maryland appears to have been spared some of the negative consequences. This is due, in part, to the fact that it has long had a case mix adjusted Medicaid reimbursement system. Such a system provides greater incentives for facilities to accept sicker Medicaid patients than a flat rate reimbursement system. Thus, in general, facilities are less dependent on Medicare here than elsewhere.

Regarding the impact of the BBA in Maryland, the Delmarva Foundation is currently one of five peer review organizations participating with the Health Care Financing Administration (HCFA) on the Skilled Nursing Facility Prospective Payment System Quality Medical Review Pilot Project. The Maryland team is comprised of Delmarva Foundation for Medical Care, the Maryland Office of Health Care Quality, Maryland Medicare/Blue Cross and Blue Shield of Maryland, and the Medical Care Finance and Compliance Administration of the Department of Health and Mental Hygiene. Delmarva developed a questionnaire that was distributed and returned with a 32 percent response rate. Results included the following findings:

- 54 percent responded that since the implementation of PPS, staffing in nursing homes has declined; there is a 45 percent increase in use of agency nurses.
- Skilled Nursing Facilities (SNFs) did not report any increase in patient falls, episodes of patient dehydration, or acquisition of pressure ulcers.
- SNFs noted a 67 percent increase in patient acuity and 68 percent have made admission requirements more stringent.
- 62 percent of the hospitals reported an increase in readmissions from SNFs.
- 76 percent of hospitals report an increase in length of stay for patients awaiting SNF placement.[22]

It should be noted that these are preliminary findings and that replies represent only at 32 percent response rate. Further data and results from this study are expected later this year.

E. Nursing Home Mergers/Acquisitions in Maryland

Mergers of long term care facilities in Maryland have occurred with increasing frequency in recent years. This may be due in part to the BBA since mergers can consolidate billing and other administrative expenses, but it may also just be a sign of the times where it is much more difficult for smaller nursing homes to survive. The chains, both national and local, that operate

[22] Rodgers, Roxanne, Delmarva Foundation. "HCFA Skilled Nursing Facility Prospective Payment System Quality Medical Review Pilot Project", June 30, 2000.

more than one facility in Maryland, are listed in Table 5. As this table indicates, 10,839 beds out of the statewide total 30,300 (or 36 percent) are operated by owners of seven multi-facility chains in Maryland.

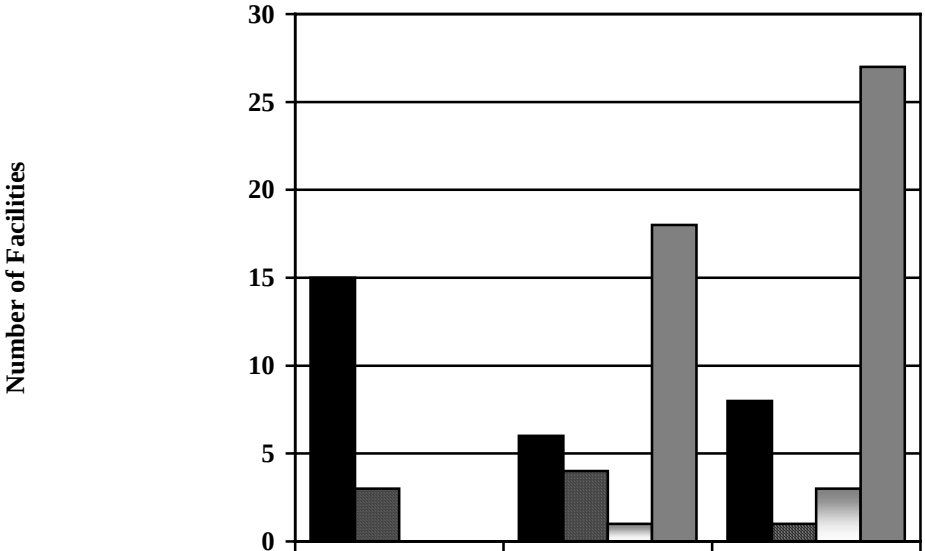
Table 5
Companies Operating Multiple Nursing Home Facilities in Maryland: 2000

Name of Company	Number of Facilities	Number of Beds
Genesis Eldercare	26	3,952
Mariner-Paragon	13	2,249
Manor Care	10	1,481
Futurecare	8*	1,192
Millenium	5	516
Meridian Elder Trust	5	771
Lorien	3**	678
TOTAL	70	10,839

*Futurecare has 8 nursing homes and 3 subacute facilities
**Lorien has 3 existing facilities and 4 under development

In Maryland, as in the rest of the country, there has been a great deal of merger activity during the past three years. Some of it has been related to changes in ownership of the facility, changes in who owns the license, or both. More recently, mergers and acquisitions have been the result of corporate restructuring. These activities, which have increased from a total of 18 facilities in 1997 to 39 in 1999, are illustrated in Figure 6.

Figure 6
Maryland Facilities Involved under Nursing Home Acquisitions: May 1997-January 2000



	1997	1998	1999
Licensee & Owner	15	6	8
Licensee Only	3	4	1
Owner Only	0	1	3
Corporate Restructuring	0	18	27

Source: Maryland Health Care Commission (Data reported based on CON project files)

IV. QUALITY OF CARE

A. Federal Quality of Care Initiatives

Nursing homes have suffered in the past few years from the simultaneous cuts in reimbursement coinciding with increased scrutiny in areas of quality of care. In order to understand the impact of these changes, one needs to have a brief history of the quality of care initiatives that have been launched in this area.

Federal Quality of Care Initiatives:

1986: The Institute of Medicine conducted a study of nursing home regulations and reported prevalent problems regarding the quality of care and the need for stronger federal regulations.

1987: The General Accounting Office (GAO) reported that over one third of nursing homes are operating below federal minimum standards. This led to the passage of the Omnibus Budget Reconciliation Act (OBRA of 1987). Part of OBRA 1987 was the comprehensive Nursing Home Reform Act (PL 100-203), which included, among other things, the development of the minimum data set (MDS).

1991: HCFA's OSCAR (Online Survey Certification and Reporting System) came online in October 1991. It listed reports for 3 previous surveys.

1995: The Nursing Home Reform Act led to new enforcement provisions outlined in the State Operations Manual (SOM) in July 1, 1995. A new HCFA certification process also began in 1995. The Ombudsman Program, which was created in 1978 under the Older Americans Act, developed the NORS (National Ombudsman Reporting System) in 1995.

1997: In 1997, the Office of the Inspector General (OIG), in a report entitled "Safeguarding Long Term Care Residents", reported great diversity in ways that states investigate patient abuse. A more in-depth audit of Maryland facilities examined eight nursing homes and found that 5% of employees had criminal records.

1998: In March 1998, Charlene Harrington published a study entitled: "The Regulation and Enforcement of Federal Nursing Home standards". She challenged the declining State deficiency averages by raising the notion that the enforcement process may be weakening rather than nursing facilities improving their quality of care. In July 1998, President Clinton announced new nursing home initiatives to provide enhanced protections and to target needed improvements in nursing home care. He called on HCFA to impose penalties on nursing facilities without establishing a grace period, inspect facilities with poor records more frequently, and establish a national databank so consumers could compare facilities against one another. Following his recommendation, HCFA granted states greater latitude to impose fines as high as $10,000 per survey infraction, eliminated grace periods for facilities with repeated violations, and pushed states to begin criminal investigations of complaints about harm to residents within 10 days. Also, in 1998, the GAO report on quality of care in 1,370 California nursing homes revealed that 30% had violations that caused death or life-threatening harm to residents, or had understated the frequency of poor care by falsifying medical records. This led to hearings held during the summer of 1998 by the Senate Special Committee on Aging.

1999: In March 1999, the OIG released a report entitled: "Quality of Care in Nursing Homes: An Overview". Among its findings: 13 out of 25 "quality of care" deficiencies have increased in recent years; ombudsman complaints have been steadily increasing; since 1995 the OIG has excluded 668 nursing home workers from participation in the Medicare/Medicaid program as a result of a conviction related to patient abuse or neglect. Recommendations include: enhance the survey and certification process; strengthen the ombudsman program; improve nursing home staffing levels; improve coordination between state survey agencies and ombudsman; a systematic assessment of OBRA 1987; and create periodic report cards on conditions in nursing homes. Also in March 1999, the GAO released a report entitled: "Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards." They found that more than one fourth of the nursing homes studied had deficiencies that caused actual harm to residents, or placed them at risk of death or serious injury. Furthermore, sanctions initiated by HCFA were never implemented in a majority of cases, and generally there was no mechanism to ensure that the homes maintained compliance with standards. Recommendations include: improve the effectiveness of civil money penalties; strengthen the use of and effect of termination; improve the referral process (referral to HCFA for sanction); develop better management information systems. In the summer of 1999, HCFA added 24 quality indicators to its survey process for Medicare-certified facilities. Facilities receive a percentile rank for each indicator that shows how the facility compares with others in the state. Facilities with an unfavorable rank will face more scrutiny by state surveyors, particularly in the area of concern. Also, HCFA will now place immediate sanctions on any facility that receives two consecutive survey citations for isolated incidents that involve actual harm to at least one resident.[23]

B. State Quality of Care Initiatives

At the same time as these federal initiatives have occurred, the State of Maryland has also launched its own quality of care investigation. Senate Bill 740 and House Bill 791, passed during the 1999 General Assembly, required the creation of a Task Force on Quality of Care in Nursing Facilities. The bill also called for reform of Medicaid's reserve bed payment policy and establishment of a nursing home report card. This was done as a result of two developments: growing recognition that nursing homes were severely understaffed, and issues raised by the March 1999 General Accounting Office (GAO) report which severely criticized Maryland's regulatory oversight of the nursing home industry. Findings of the GAO Report regarding Maryland include findings that Maryland:

- dedicated fewer resources to investigating complaints than other states surveyed;
- recorded substantially fewer complaints than Michigan or Wisconsin;
- generally classified similar complaints as needing less prompt investigation;
- did not meet the assigned time frames for investigating many complaints; and
- had a large backlog of uninvestigated cases and poor tracking of the status of investigations.

"As a consequence, serious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months in Maryland. Such delays can prolong situations in which residents may be subject to abuse or neglect resulting in serious care problems like malnutrition and dehydration, preventable accidents, and medication errors."[24]

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[23] Office of the Inspector General, Quality of Care in Nursing Homes: An Overview, March 1999 (OEI-02-99-00060). Also General Accounting Office, Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards, March, 1999 (GAO/HEHS-99-46).

[24] General Accounting Office. Nursing Homes Complaint Investigation Processes in Maryland. June, 1999. (GAO/T-HEHS-99-146)

Staffing issues were brought to the General Assembly's attention by the local chapter of Service Employees International Union (SEIU), District 1199E.

The Maryland Nursing Home Task Force met from July to December of 1999. It included public comments from all major stakeholders. Findings were as follows:

- Nursing home residents have more complex and acute medical needs than in previous decades.
- Personal care needs of residents are not being met. There has been a decline in the quality of care in Maryland's nursing homes.
- Nursing Assistants, who provide most of the care in the homes, are in a position with little mobility, limited opportunity, and poor pay. The result is large turnover in these positions and continued staff shortages.
- The Balanced Budget Act of 1997 reduced federal reimbursement to nursing homes.
- The 1998 federal nursing home initiatives (NHIs) have had a major resource impact on Maryland's regulatory system. This impact is compounded by the Office of Health Care Quality's (OHCQ) difficulty in recruiting qualified survey staff.
- In response to the GAO report and new directives from HCFA, OHCQ has made complaint investigation a higher priority.
- State licensure laws for enforcing action against nursing homes with poor quality of care are not effective. These laws do not lead to early intervention and the encouragement of nursing homes to achieve and maintain compliance with standards. At present, enforcement action for nursing homes with poor quality is dependent on federal regulations.
- Maryland nursing homes are not practicing internal health quality assurance and as a result are less proactive in dealing with issues.
- Advocacy efforts on behalf of nursing home residents are underfunded and need to be strengthened. In particular, the long-term care ombudsman program does not have the resources to do its job.
- Family Councils can be a valuable source of advocacy for residents, provided that they operate independently of nursing home administration.

Recommendations from the Task Force include:

- Continue the Task Force as an oversight committee to monitor progress on the implementation of its recommendations.
- Increase minimum staffing standards for resident care in nursing homes to four hours per resident per day, with unlicensed direct care staffing set at a minimum of three hours per resident per day.
- Improve the quality of the nursing home workforce.
- Strengthen State regulation of nursing homes.
- Improve quality assurance programs in nursing homes.
- Strengthen consumer advocacy, including the long-term care ombudsman program.

Another provision of SB 740 was for the Maryland Health Care Commission to "develop and implement a system to comparatively evaluate the quality of care and performance of

nursing facilities on an objective basis". The Commission formed a Nursing Home Report Card Steering Committee to develop nursing home report cards. A report on this effort needs to be made to the Governor and the General Assembly by January 1, 2001.

During the 2000 session of the General Assembly, quality of care in nursing homes was again a major focus of activity. Following the work of the Maryland Nursing Home Task Force, seven bills addressing quality concerns were considered, and six passed. They include the following:

- **HB 784/SB794**: $40 million added to the Medicaid budget over the next two years to support increased staffing in nursing homes. A provision increasing staffing requirements to 4.0 nursing hours per day was defeated.
- **HB 747/SB690**: Require nursing homes to create a quality assurance program, a quality assurance committee, a written quality assurance plan, require facilities to post staffing ratios.
- **HB 634/SB689**: Provides the Department of Health and Mental Hygiene (DHMH) with the authority to impose sanctions and penalties instead of federal sanctions and penalties including civil money penalties.
- **HB 748/SB 688**: Requires DHMH to conduct two full inspections each year unless a facility has been deficiency-free on two consecutive surveys.
- **HB 748/ SB 698**: Continues the Nursing Home Task Force as an oversight body.
- **HB 865**: Contained a budget increase to expand the state's ombudsman program with an additional $1.9 million over the next three years.

In addition, SB 435, which would have created an awards program for nursing assistants financed by charging $750 for follow-up inspection visits, was defeated.

Another effort in the area of quality of care in nursing homes is a joint program of the Mid-Atlantic Non-Profit Health and Housing Association (MANPHA), the Maryland Medical Directors Association (MMDA) and the Health Facilities Association of Maryland (HFAM), to develop clinical practice guidelines for use in nursing homes. The Maryland Office of Health Care Quality will recognize use of these guidelines as an initiative under the Omnibus Budget Reconciliation Act (OBRA) regulations.

Some members of the nursing home industry feel that this focus in quality assurance has changed from offering assistance to being punitive. Others feel that the focus on quality has caused more resources to be devoted to nursing homes, with increased staffing where they are needed. In either case, this is another responsibility imposed on the nursing home industry.

V. ALTERNATIVES TO INSTITUTIONALIZATION

A. Public Image of Nursing Homes

Besides facing financial pressures and quality concerns, nursing homes are also facing a public relations challenge. In public opinion polls, many Americans say that they will go "anywhere but a nursing home". The American Health Care Association (AHCA), recognizing this issue, launched an initiative called "SecureCare" in 1997. While aimed at finance reform, it also tried to address the public relations problems in American nursing homes. Again for the Year 2000, an area of concentration identified by AHCA for this year is "the generation of positive news stories".[25] At a local level, the Mid-Atlantic Non-Profit Health and Housing Association announced in its June 2000 newsletter that it wants to emphasize the positive in a new section entitled "Beyond the Call of Duty"; its purpose is to "be a step in countering the negative publicity that providers have endured from the mainstream press."[26]

When nursing homes first emerged in the 1960s, they were viewed by some as "places to die". As the nursing home industry developed more of a medical model, and as hospitals discharged patients earlier, they were able to develop more consumer confidence as nursing homes approached "mini hospitals". If former HCFA Commissioner Bruce Vladek's opinion is any indication, nursing homes have a long way to go to improve their image: "[nursing home] residents live out the last of their days in an enclosed society without privacy, dignity, or pleasure, subsisting on minimally palatable diets, multiple sedatives, and large doses of television---eventually dying, one suspects at least partially of boredom."[27]

Alan Solomont, former Finance Chairman of the Democratic National Committee (DNC) and Co-Chair and Co-Chief Executive Officer of Solomont Bailis Ventures, predicts: "long term care is not going to shrink, but it isn't going to grow at the same rate at which it did in the mid 90s." He foresees an industry shakedown over the next year or so as providers shed debt and compensate for decreased Medicare revenue growth. "The industry is going to move back a few steps and once again focus on its core Medicaid business."[28]

In the past, nursing homes had become the focus of the long-term care industry. Now, with a tremendous growth of home health, development of adult day care, and proliferation of assisted living, consumers have a wide range of alternatives from which to choose. "Growth in spending for nursing home care decelerated steadily from 13.3 percent in 1990 to 3.7 percent in 1998, matching the slowest previous growth record in 1961. Much of the deceleration in growth since 1990 was the result of slowing growth in medical price increases and expanded use of alternative treatment settings such as home health care, assisted living facilities, and community-based day care."[29]

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[25] HFAM, Networks, February 2000, Volume III, Issue 1.
[26] MANPHA Monthly Mail, Vol. 7., No. 5, June, 2000.
[27] Bodenheimer, Thomas, op.cit., p. 1324.
[28] Childs, Nathan, op.cit., p. 43.
[29] Levit, Katherine, et. al. "Health Spending in 1998: Signals of Change", Health Affairs 19(1):1124-1342.

B. Home Health Care Services

The Medicare home health program was started in 1965 as a humane concept of providing care for persons in their home and aiding recovery in a familiar environment. There were many reasons for an interest in home care including: "reducing the financial burden of Medicaid nursing home spending on federal and state governments, the impoverishing consequences of the use of nursing homes by older people with disabilities, and the general preference of older people for home care." [30]The concept was popular, and based on the ready availability of Medicare funding, the growth of home health services has been phenomenal. However, there is now serious concern with the rate of growth and its effects on Medicare spending nationally. Home health care reimbursements have grown by 300 percent nationally in the past six years alone.[31]

The rapid growth of home health care and its impact on the Medicare budget made the industry a focus of federal investigation. In 1995, a comprehensive anti-fraud initiative, Operation Restore Trust, was initiated. During this time, the Department of Health and Human Services' Inspector General and the General Accounting Office conducted investigations of certain states' home health agencies, finding various instances of inappropriate payment and cases of fraudulent behavior. In response to this, one focus of the BBA was on the home health program with the intention to slow the rate of expenditure growth, provide incentives for efficiency in the delivery of care, and ensure that Medicare pays appropriately for services.[32]

Questions have been raised on the degree to which home health substitutes for nursing home care. To the extent that nursing homes provide long-term custodial care, home health probably does not substitute. However, as nursing homes increasingly serve more short-stay, post-acute and subacute patients discharged from hospitals, there is probably more overlap in their populations.

C. Assisted Living

A study by Christine Bishop notes that an increasing number of nursing home residents are moving into alternative placements, such as assisted living, and she sees these trends continuing. Some of the shift is due to the falling prevalence of disability. However, a greater influence is the preference for less institutional placement. This has resulted in lower utilization rates for nursing homes. Comparing data from the National Nursing Home Surveys, Bishop found that the percent of Americans 65 and older, who lived in nursing homes, fell from 4.6 percent in 1985 to 4.2 percent in 1995. [33] For Maryland, using more recent data, the percentage of the population aged 65 and over, who were residents of nursing homes fell from 4.14 percent in 1990 to 3.78 percent in 1997.[34]

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[30] Liu, Korbin et. al., "Changes in Home Care Use by Older People with Disabilities: 1982-1994", Public Policy Institute, AARP, January, 2000.
[31] Havemann, Judith. "Fraud is Rife in Home Care for the Elderly". Washington Post, April 29,1997.
[32] MHCC, Maryland Home Health Agency Statistical Profile: FY 1998 and Trend Analysis: FY 1996-1998, June, 2000.
[33] Assisted Living Executive Report, Vol, 4, No. 4, February 16, 2000.
[34] Maryland Health Care Commission long term care survey data. Data based on residents of nursing homes who were Maryland (excludes out of state) residents aged 65+ as a proportion of Maryland population aged 65+.

Assisted living is also a growth industry. It is difficult to get an exact count of assisted living facilities since there is no single definition that is applied consistently nationwide. Regulations and licensure vary by state, and such facilities are often classified as domiciliary care, residential care, or personal care, etc. The Assisted Living Federation of America estimates that there were 362,014 assisted living beds in 1991, compared to 777,801 in 1999, a growth rate of over 114 percent.[35]

In Maryland, Dianne Dorlester, Executive Director of Maryland Assisted Living Association (MALA) estimates that there are currently 13,000 to 15,000 persons in 2,500 assisted living facilities in Maryland.[36] Previously in Maryland, there were many types of residential programs governed by different regulations under different state agencies. Programs previously licensed under the Department of Health and Mental Hygiene (domiciliary care), the Department of Human Resources (Project HOME) and the Office on Aging, now the Department of Aging (sheltered housing) are now combined under the assisted living classification. Under regulations developed in July, 1998 in response to legislation passed in 1996, the Office of Health Care Quality now inspects and licenses all assisted living programs in Maryland. In addition, the Medicaid Program has received a waiver from HCFA to be able to fund assisted living in Maryland. Expansion of the current number of individuals enrolled and served by current providers will occur on July 1, 2000; all other parts of the waiver will be effective January 1, 2001. With Medicaid funding for what is now largely private pay service, it would be expected that use of these facilities would increase at an even faster rate. In the future, there will be a need to collect data and monitor the growth of assisted living in Maryland in order to monitor its impact on the long term care system.

The development and increasing popularity of assisted living has taken a financial toll on nursing homes. Though some of the decrease in utilization may be due to the falling prevalence of disability, shifts in utilization to other settings is a more important factor. Comparing National Nursing Home Survey data, the number of American 65 and older who lived in nursing homes fell from 4.6 percent in 1985 to 4.2 percent in 1995.[37] The current rates may be even lower.

Because of the impact of alternatives, many nursing homes have recognized that they must diversify to survive in the future. Many are branching into other types of care in order to survive, and to meet the needs of the growing elderly population that is demanding more alternatives. A survey conducted in 1997 by the American Health Care Association (AHCA) found that its members offered several alternative services as follows: contract rehabilitation (26.5 percent); assisted living (21.7 percent); subacute (12.7 percent); adult day care (5.4 percent) home care (3.0 percent).[38]

For many years, nursing homes have had to compete with other models of care. The models are becoming more prevalent and more widely accepted. A few examples will be reviewed here: continuing care retirement communities (CCRCs); the Program of All-Inclusive Care for the Elderly (PACE); and Social Health Maintenance Organizations (S/HMOs).

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[35] "Too Much too Soon Halts Assisted Living Boom", The New York Times, May 28, 2000.
[36] Lynch, Heather. "Assisted Living Facilities: a Fast-Growing Niche for Developers, Architects, Builders". Daily Record, February, 2000.
[37] Bishop, Christine, cited in Assisted Living Executive Report, Vol 4, No. 4, February 16, 2000.
[38] HCIA and Arthur Andersen, The Guide to the Nursing Home Industry, 1998, p. x.

D. Continuing Care Retirement Communities

Continuing Care Retirement Communities as a model have existed in Maryland since the 1970s. However, they have grown from 14 in 1980 to 30 today (a growth rate of 114 percent). Now, twelve counties are served by CCRCs, with a total of 2,350 nursing home beds. One of the appeals of CCRCs is that they offer an insurance model; that is, at least for the original type of CCRC model, a subscriber pays an entrance fee and monthly fees that cover all long term care services in exchange for a promise to provide a full range of care. The early CCRCs involved a transfer of assets. Many were church-sponsored and a prospective resident would have to give up his assets in exchange for lifetime care. The model then changed to continuing care, where a person paid an entrance fee and monthly fees and was guaranteed a full range of social, personal, nursing, and medical services, including nursing home care when needed. In order to keep prices more competitive, many CCRCs offer an "a la carte" model where the person pays an entrance fee, but pays lower monthly fees for lower levels of care. Thus, a person can pay for an independent living unit for many years before experiencing an increase in fees for assisted living, nursing home, or other special services.

Although CCRCs were always potentially in competition with nursing homes for the same patient pool, especially those with the financial resources to be private pay, for the most part, the two groups had distinct roles. For the most part, nursing homes provided "traditional" custodial care or post acute care, while CCRCs provided housing with some health services. CCRCs need to receive both certification from the Department of Aging as well as a Certificate of Need (CON) from MHCC. Under current law, a CCRC needs to either obtain a CON, in which case it could serve the general public the same as any other nursing home, or obtain an exemption from CON, which permits it to serve only its own residents who have signed contracts to live in independent and assisted living units in the community.

Recent legislation, passed during the 2000 legislative session, modified the CON regulation for CCRCs. First, SB 403 modified the number of CON exempt nursing home beds that a community can obtain. In the past, the number of beds was 20 percent, or a one to five ratio of beds to independent living units. Under this new legislation, a CCRC with fewer than 300 independent living units would be able to obtain nursing home beds at 24 percent of the number of independent living units[39]; for communities with more than 300 independent living units, the 20 percent figure remains unchanged. This bill goes into effect October 1, 2000.

In addition, SB 146 permits limited direct admission of persons from the general community into nursing home beds at CCRCs under certain circumstances:

1. The entrance fees paid prior to entering the community must be at least equal to the lowest entrance fee charged for an independent living unit or an assisted living unit.
2. The CCRC may admit a subscriber directly into a comprehensive care bed only if, at the time of admission, the subscriber has the potential for an eventual transfer to an independent living unit or an assisted living unit. This must be determined by the subscriber's personal physician, who is not an owner or employee of the CCRC.

[39] Note: This computation does not include the number of assisted living units.

3. The total number of comprehensive care beds occupied by subscribers who have been directly admitted from the general public may not exceed 20 percent of the total number of comprehensive care beds at that CCRC.
4. The CCRC must not admit a subscriber directly from the general community into a comprehensive care bed if that admission would cause the occupancy of the comprehensive care beds to exceed 95 percent.

It should be noted that SB 146 sunsets on June 30, 2002. Therefore, it will be necessary to collect data and carefully monitor the impact of this legislation and the resulting regulations on both the CCRC and nursing home industries.

Statewide, there are currently 30 CCRCs operating in Maryland. Twenty-six (26) of the 30 CCRCs operate their own nursing home facilities as a component of their services available on the campus of the community. As of March 8, 2000, those CCRCs operated a total of 7,618 independent living units, 1,591 assisted living units, and 2,350 nursing home beds.

Of the CCRCs with nursing home facilities, 12 have received a CON exemption for nursing home beds. The remaining 14 CCRCs have CON approved or grandfathered nursing home beds. As shown in Table 6, the 12 CCRCs with CON exemptions operate a total of 938 nursing home beds. More than one-half of those CON exempt nursing home beds are located in two CCRCs (Charlestown and Oakcrest Village) operated by Senior Campus Living. In addition to facilities currently in operation, data maintained by the Department of Aging indicates that four new CCRCs are currently under development with a total of 539 additional nursing home beds.

Table 6
Maryland Continuing Care Retirement Communities with CON Exempt Nursing Home Beds: March 8, 2000

CCRC	Jurisdiction	Year Opened	Independent Living Units	Assisted Living Beds	Nursing Home Beds
Ginger Cove	Anne Arundel County	1989	243	6	55
Blakehurst	Baltimore County	1993	278	14	54
Charlestown	Baltimore County	1983	1,614	164	270
Glen Meadows	Baltimore County	1990	213	29	31
North Oaks	Baltimore County	1990	183	13	37
Oak Crest Village	Baltimore County	1995	1,528	143	240
Asbury-Solomons	Calvert County	1996	208	30	42
Vantage House	Howard County	1990	220	26	44
Heron Point	Kent County	1991	192	16	36
Buckingham's Choice	Frederick County	2000	207	45	41
Bedford Court*	Montgomery County	1992	215	76	60
Maplewood Park Place*	Montgomery County	1995	207	21	28
TOTAL			**5,308**	**583**	**938**

*Note: Bedford Court and Maplewood Park Place have leased nursing home beds in addition to CON exempt beds.

Another variation on the CCRC model is Continuing Care at Home. This is a program that exists in some other states that permits some of the benefits of CCRCs while allowing persons to stay in their own home. Basic services to be provided include:

- Care coordination;
- Home inspection by occupational therapist;
- Assistance with activities of daily living at home;
- Skilled nursing services at home;
- Services in assisted living;
- Services in comprehensive care facility;
- Assistance with home maintenance.

Services are paid for by an entrance fee, regular periodic charges, co-payment, or a combination of funding arrangements. These regulations went into effect in Maryland May 15, 2000. The Department of Aging, which will regulate Continuing Care at Home, does not expect a large number of providers. It estimates three applicants during the first year.

E. Program for All-Inclusive Care for the Elderly (PACE)

PACE, the Program for All-Inclusive Care for the Elderly, is a capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity that features a comprehensive medical and social delivery system using a multidisciplinary team approach in an adult day health center, supplemented by in-home and referral services in accordance with the participants' needs. It was originally based on a program in 1971 called On Lok Senior Health Services in San Francisco. This model provided a range of both acute and long-term care services to an enrolled community. This type of care expanded in 1986 when the Robert Wood Johnson Foundation provided funding for PACE demonstration sites to test if the model could be applied on a broader scale to many types of populations.[40]

The BBA of 1997 established PACE as a permanent entity within the Medicare program and enables States to provide PACE services to Medicaid beneficiaries as a state option. PACE beneficiaries need to be frail enough to satisfy their state's requirements for nursing home level of care. The BBA limits annual growth of the PACE program, The number of PACE agreements in the first year is 60 nationally; the limit increases by 20 each year thereafter.[41]

In January 1996, Hopkins Elder Plus initiated a pre-PACE site, which received partial Medicaid capitation for dual eligibles aged 65 and over who were certified for nursing facility level of care. A dual waiver proposal for full capitation by Medicare and Medicaid was jointly submitted to HCFA in June 1998 by The Maryland Department of Health and Mental Hygiene and Johns Hopkins Bayview Medical Center. In January 1999, HCFA approved the waiver proposal, which was implemented in March 1999.[42]

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[40] PACE information from HCFA WEBSITE: http://www.hcfa.gov/
[41] Ibid.
[42] Information from DHMH WEBSITE: http://www.dhmh.state.md.us/hsaea/

F. Social Health Maintenance Organizations (S/HMOs)

Social Health Maintenance Organizations (S/HMOs) are also based on early models and HCFA demonstrations. A S/HMO is an organization that provides the full range of Medicare benefits offered by standard HMOs plus additional services which include: care coordination, prescription drug benefits, chronic care benefits covering short term nursing home care, a full range of home and community based services, such as homemaker, personal care services, adult day care, respite care, and medical transportation. Other services that may be offered include: eyeglasses, hearing aids, and prescription benefits. There were four original S/HMOs : Portland, Oregon; Long Beach, California; Brooklyn, New York; and La Vegas, Nevada. Each site has different requirements for premiums; persons do have to pay co-pays for certain services.[43]

In March 1998, HCFA approved Maryland's proposal for a planing grant to build on a Medicare HMO, develop a Second Generation S/HMO (S/HMO II) for Medicare-only and dually eligible (Medicare and Medicaid) older adults, and add long-term care and other services. HCFA approved a no-cost extension of the planning project through June 2000.[44]

A recent study found that S/HMO membership does not offer savings as expected. When comparing the expenditures of enrollees in the Minneapolis S/HMO with those in a TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) HMO, results showed that outpatient services common to both the S/HMO and the TEFRA HMO were about 16 percent higher for S/HMO enrollees, and expenditures for all services were about 20 to 22 percent higher for S/HMO enrollees. The report does not indicate how costs compare to traditional care. The researchers speculate that health care providers might have discovered health problems that would otherwise have gone undetected, recommended medical attention for chronic problems, and helped to link patients with other medical providers, thus causing higher expenditures.

All of these models have their limitations. CCRCs have worked well for a population who can afford to pay for services; this model has not been widely applied to lower socio-economic groups. Both PACE and S/HMOs have been tested on a relatively small scale. There are limitations in the populations who can enroll in terms of medical need, financial resources, and limited catchment areas. These models probably cannot be expanded on a broad scale. However, they can offer insights on how to provide long term care services in ways that may be more effective than traditional methods of delivering care.

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[43] S/HMO information from Medicare Website: http://www.medicare.gov/
[44] Information from DHMH Website, op.cit.

VI. LOOKING FORWARD

A. Consumer Choice

One impact being felt throughout the health care system, and in other areas of life as well, is the impact of consumer choice. As baby boomers age, they are demanding more options, more personal input, more choices. Moreover, this generation of seniors is by and large better educated. Between 1970 and 1998, the percentage of those 65 and older who had completed high school rose from 28 percent to 67 percent. About 15 percent in 1998 had a bachelor's degree or more.[45]

With increasing education comes increasing income and better chances of good health. A survey done based on the Behavioral Risk Factor Surveillance System from 1993-1997 shows that for each age group, with increasing education and income, fewer people rate their health as fair or poor as shown in Table 7. This, combined with findings of lower disability levels, as discussed earlier, suggests that in the future people may be able to postpone the need for long term care services. For this reason, care must be taken in using past utilization rates to project forward in determining the need for services.

The elderly of tomorrow will live longer and want to make the most of their time. They are used to having a menu of choices, and do not accept the old "father knows best" approach to medicine or health care services. Another factor to consider is the explosion of information on the Internet. With so many medical resources at everyone's fingertips, people are more likely to question the advice they are given.

[45] Administration on Aging , Profile of Older Americans: 1999. Website: http://www.aoa.dhhs.gov/aoa

TABLE 7
Percentage of Fair or Poor Self-Rated Health Reported by Older Adults, by Selected Demographic and Risk Factors: U.S., 1993-1997

	Age group (yrs)					
	55-64 (n = 64,919)		65-74 (n = 67,469)		≥ 75 (n = 46,458)	
	Male (n = 26,820)	Female (n = 38,099)	Male (n = 25,840)	Female (n = 41,629)	Male (n = 13,890)	Female (n = 32,568)
Characteristic	%	%	%	%	%	%
Total	**21.1**	**20.8**	**25.9**	**26.5**	**32.8**	**34.4**
Race						
White	19.8	18.3	24.7	24.6	32.1	33.5
Black	31.4	36.5	39.8	43.3	42.8	46.5
Asian/Pacific Islander	16.3	19.3	22.1	18.2	25.6	28.6
Native American/ Alaskan Native	23.2	44.1	32.5	42.0	48.7	38.9
Hispanic ethnicity*						
Yes	33.9	37.3	32.7	39.3	39.5	45.8
No	20.3	19.7	25.5	25.9	32.6	34.0
Educational level						
Less than high school graduate	42.2	43.5	40.7	42.4	43.3	44.8
High school graduate	21.7	19.5	25.9	24.9	30.7	32.7
Some college	17.9	14.4	22.1	19.2	29	27.2
College graduate	9.6	8.5	13.3	13.1	23.1	22.3
Annual household income						
<$15,000	51.1	44.3	42.8	38.1	42.9	41.6
$15,000 - $24,999	28.8	22.5	30.3	25.7	34.2	31.7
$25,000 - $34,999	21.2	16.1	19.6	18.0	25.3	25.5
$35,000 - $49,999	14.4	10.5	13.6	13.8	24.6	22.5
≥$50,000	10.8	13.3	17.3	26.3	27.3	32.2
Employment status						
Employed	12.6	11.3	15.1	13.8	17.2	15.0
Out of work	32.0	31.9	31.2	30.2	52.7	29.1
Homemaker	37.3	22.4	0	28.1	0	34.3
Retired	23.2	20.0	26.5	26.1	33.4	34.0
Unable to work	79.3	75.5	75.0	74.3	64.4	73.5

Note: Total population=178,846. The sample sizes are for known data regarding age, sex, and self-rated health status.

Source: U.S. Dept. of Health and Human Services, Centers for Disease Control, Surveillance for Selected Public Health Indicators Affecting Older Adults-U.S., Vol. 48, No. SS-8, December 17, 1999.

Some feel that there are two inescapable facts guiding predictions of the future: "One is that Americans are getting older. The other is that they are getting smarter—or at least better-educated."[46] According to a recent study by Harvard University, as the education level among seniors rises, fewer seniors become disabled, leading to less demand for various types of eldercare programs.[47] The prediction is that, with managed care in the future, the client will do

[46] Keaveney, Bob. "Older and Wiser Americans Drive Health Care Future" The Daily Record, Nov. 2, 1999.
[47] "Better Educated, Higher-Income Seniors have Less Need for Senior Housing", Assisted Living Executive Report, June 7, 2000.

more managing of his or her own care, but will also pay a higher price for that care. Prevention will also play a part; aging baby boomers are interested in exercise and preventive services that will hopefully delay disability and improve the quality of life.

B. Future Directions

Predicting the future is always a challenge, perhaps even more so during a time of rapid change. Although there is disagreement as to the future of the long term care system, all agree that more change is inevitable.

Nursing Homes:

- Successful nursing homes will change their orientation in the future. The reimbursement crisis is not short term. Although some cuts have been restored, the government will not go back to retrospective reimbursement of costs. Nursing homes will need to be more efficient in delivering care. The adequacy and availability of professional and paraprofessional staff in long term care will remain a serious issue.

- Nursing homes will need to become more sophisticated in the use of information systems. Instead of seeing data collection as an added burden, it should be viewed as a means for assessing quality and determining reimbursement. The use of the minimum data set (MDS) will be a critical component of nursing home care.

- Nursing homes need to become more adept at "market share" analysis in order to monitor their response to change. They need to keep abreast of changes at the state and federal level and to anticipate the likely impact of such changes.

- Some facilities may choose to specialize. In the future, consumers will do more shopping for care. With the development of the HCFA website, *Nursing Home Compare*, and nursing home report cards, nursing homes need to market themselves as providing a unique service. Some nursing homes have specialized Alzheimer's units, while others focus on therapy or wound care.

- Nursing homes need to diversify and become part of networks of care. Some might align with hospitals to provide post-acute care for their patients. Others might develop an assisted living section on the same campus to provide an integrated continuum of care. Still others may develop home care agencies to allow them to follow up residents as they are discharged from the nursing home.

- Nursing homes will not grow at their past rates, but they will not disappear either. There is a place for nursing homes, but they must be integrated into the continuum of long term care.

- Alternative sites for care must be developed. According to research done by the Agency for Healthcare Research and Quality (AHRQ), depending on the criteria used, from 15 percent to 70 percent of those persons currently served in nursing homes could be cared for at lower

levels of care.[48] That addresses those already in nursing homes. According to polls, few people prior to admission prefer nursing home placement to other alternatives.

Public Policy:

In addition to the nursing home industry, the Maryland Health Care Commission and other public agencies need to adjust their perspective in planning for the long term care system. In the future, different strategies will be needed to address issues of access, cost, and quality.

- Planning needs to encompass the full continuum of long term care services. Recent history shows that changes in one sector have serious implications for other sectors of the health care system. For example, changes in hospital reimbursement have an impact on nursing homes; similarly, development of assisted living has an impact on nursing homes. Planning and regulatory strategies for one service must take into account other sectors.

- Public policy must take into account the need for choices. Aging baby boomers are better educated, wealthier, and have access to more up to date information than their parents' generation. They will demand more input in their health care decisions and more choices in their living arrangements.

- Planning in the future will be data-driven. In order to formulate public policy, there will be a need for comprehensive, up-to-date data from many sources. One cannot rely on data solely from the nursing home industry. Data from assisted living facilities, home health, adult day care, and other settings will play a part. Data collection and analysis techniques will need to focus on tracing persons through the health care system, linking care provided in various sites, and developing outcome measures.

- Nursing homes will definitely play a role in the future, but, as described above, they will not be the only players. Just as providers need to find ways to work together, public policy makers need to find ways of reviewing and regulating joint or merged systems of care.

- In planning for the long term care system, one must anticipate that the utilization rates in the future will be different from those in the past. People are more active and are living longer. Disability rates are declining. New medical techniques can decrease dependence in activities of daily living. Planning must take into account a range of scenarios rather than to assume that use rates in the future will be the same as in the past.

- One of the biggest challenges for public policy in the future will be how to pay for long term care and the role of public versus private financing of that care. Models of care in the future will emphasize the integration of acute and long term care and the development of an integrated continuum of care.

[48] Agency for Healthcare Research and Quality, Research Activities, Vol 191, March 1996.

In the past, nursing homes could open their doors and people would come. The Certificate of Need program was used to manage the growth of the nursing home industry. At that time, demographic projections were used to extrapolate how many nursing homes would be needed in the future for the growing elderly population. Now, we are in an era of managing the shrinkage of the industry. "The public saw nursing homes as a terrific invention in the 1960s and '70s, but now the industry faces questions regarding its reputation for providing care and its financial viability. Consumers have become more informed, and the nursing home industry must be able to compete in this realm to survive. Successful nursing homes will be those who create the right mix of services, giving the public what it wants while retaining the revenues they need to survive."[49]

[49] HCIA and Arthur Andersen, The Guide to the Nursing Home Industry, 2000.

APPENDIX A

MARYLAND AND FEDERAL LONG TERM CARE POLICY INITIATIVES: 1965-2000*

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* Items in regular print are federal initiatives; *items in Italics are state programs*

1965-1969

- Medicare, Medicaid, and Older Americans Act enacted by the U.S. Congress
- ***Nursing Home Regulations implemented in Maryland***
- ***Maryland's Comprehensive Health Planning Agency established***
- ***Geriatric Evaluation Services (GES) established in Maryland***

1970-1979

- *Certificate of Need (CON) process established in Maryland*
- ***Adult Day Care Division in DHMH authorized***
- ***Community Home Care Services established by the General Assembly***
- Social Services Block Grants established by the U.S. Congress
- ***Maryland Nutrition Program for the elderly established***
- ***Maryland Office on Aging established***
- ***Sheltered Housing Program began***
- ***Project HOME began in the Department of Human Resources***
- Deinstitutionalization of patients from State mental hospitals mandated by the General Assembly
- The Ombudsman Program created under the Older Americans Act
- *First State Health Plan section on Long Term Care developed*

1980-1989

- ***Medical Day Care began in Maryland***
- ***Maryland Medicaid Personal Care Program begun***
- ***Statewide Respite Care Program for persons with developmental disabilities established***
- ***Institute of Medicine conducted a study of nursing home regulations and reported prevalent problems regarding the quality of care and need for stronger federal regulations***
- GAO reported that over one third of nursing homes are operating below federal minimum standards. This led to the passage of the Omnibus Budget Reconciliation Act (OBRA of 1987).
- Part of OBRA 1987 was the Comprehensive Nursing Home Reform Act (PL100-203) which included the development of the minimum data set (MDS)
- *Maryland one of ten sites for* National Long Term Care Channeling Demonstration

- ***Interagency Committee on Aging Services established***
- ***Maryland Health Resources Planning Commission established***
- ***Maryland Medicaid nursing home case mix reimbursement system initiated***
- ***Biannual Maryland Long Term Care Survey initiated***
- Gateway II established *in Maryland*
- ***Governor's Task Force on Alzheimer's Disease and Related Disorders convened***
- ***Developmental Disabilities Home and Community-Based Waiver received***
- ***Domiciliary Care Facilities Board created***
- ***Governor's Task Force on Elder Abuse and Neglect convened***
- ***Project HOME expanded eligible population, changed name to C.A.R.E. Program***
- Statewide Evaluation and Planning Services (STEPS) established (pre-admission screening program)
- ***Governor's Housing Initiative***
- *Statewide Specialized Transportation Program (SSTAP) established*
- *Maryland Medicaid Home Care for Technology Assisted Children waiver in effect*
- *Respite Care for Functionally Disabled Adults enacted by General Assembly*
- *Pre-admission Screening and Annual Resident Review (PASSAR) begun*
- *State Health Plan sections developed on: Institutional Long Term Care; Residential Long Term Care; Community-Based Services; Hospice; Home Health; Life Care Services*

1990-2000

- HCFA's OSCAR (Online Survey Certification and Reporting System) came online.
- The Nursing Home Reform act led to new enforcement provisions outlined in the State Operations Manual (SOM) in 1995. A new HCFA certification process also began in 1995. The Ombudsman Program developed NORS (National Ombudsman Reporting System) in 1995
- Balanced Budget Act (BBA) passes, changing payment for nursing home and home health care to prospective payment system
- Balanced Budget Refinement Act passes, making some changes to the impact of the BBA
- ***Rehabilitation Organization and Management Panel issued report***
- ***Governor's Task Force on Services to the Elderly convened***
- *Final Report of the Long Term Care Committee of the Governor's Commission on Health Care Policy and Financing Issues*
- *MHRPC changes Maryland Long Term Care Survey to an annual survey*
- *1915c waiver approved using Senior Assisted Housing*
- *State Health Plan section developed that integrates all Long Term Care Services, both institutional and community-based, into a single plan section*
- *Nursing home bed need methodology developed that reduces nursing home bed need projections by substituting adult day care for certain light care residents*

- ***DHMH/Milbank Memorial Fund Long Term Care Retreat held***
- ***Maryland Health Care Decisions Act enacted by General Assembly***
- ***Governor's Task Force on Assisted Living-legislation enacted, regulations developed***
- ***Long Term Managed Care Advisory Committee convened***
- In March, 1999 both OIG and GAO release studies on the quality of care in nursing homes, making recommendations to change the survey and certification process. The GAO Report severely criticized Maryland's regulatory oversight of the nursing home industry
- Task Force on Quality of Care in Nursing Facilities. The group made recommendations, seven bills were introduced during the 2000 session of the General Assembly, and six were passed
- Maryland Health Care Commission begins work on development of nursing home report cards
- October, 1999 the Maryland Health Care Commission was formed by the merger of the Maryland Health Care Access and Cost Commission and the Maryland Health Resources Planning Commission
- *Medicaid applied to HCFA for, and obtained, a waiver to cover assisted living services.*